Thomas (T. G.)

LAPAROTOMY

PERFORMED FOR THE REMOVAL OF A LARGE QUANTITY OF MENSTRUAL BLOOD FROM ONE HORN OF A BICORNATE UTERUS.

BY T. GAILLARD THOMAS, M.D.,

Surgeon to N. Y. State Woman's Hospital.

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BY T. GAILLARD THOMAS, M.D.,

Surgeon to N. Y. State Woman's Hospital.

Mrs. A., a native of France, forty years of age, a widow, who had borne one child, entered my service in the Woman's Hospital, and gave the following history. For the past sixteen years she had suffered from what a large number of physicians who had examined her had uniformly pronounced to be a fibrous tumor of the uterus. At the commencement of that period she had spent eight months in the hospitals of Paris, and had since consulted many physicians, but without obtaining any relief whatsoever. The three distinguishing features of her case were these: first, since its development the tumor had neither increased nor diminished in size; second, it was at all times exquisitely sensitive to pressure, and especially so during menstruation; and, third, pain occurred in it during every menstrual act, so severe that nothing gave her relief except a free resort to opium. Her suffering during menstruation I have never seen surpassed, and she had become so demoralized by it that her object in entering the hospital was to have the growth removed at all hazards.

Upon examining her I found the pelvis filled by a tumor about as large as the head of a child a year old, which, as I have already said, was very sensitive to pressure. It was apparently solid, only slightly movable, and by conjoined manipulation appeared to be attached directly to the uterus. I saw no reason to differ from the diagnosis which had been heretofore made in the case, although I was very much puzzled by the existence of the three peculiar features to which I have already referred.

I dissuaded the patient from operation, but she was so much distressed at this that I got my colleagues, Dr. T. A. Emmet and Dr. J. B. Hunter to see her with me in consultation; she indulging the hope that they might differ with me in this regard, and declaring that so great were her sufferings that she would infinitely prefer a resort to surgical interference, however great the dangers might be, than to remain exposed to them. Drs. Emmet and Hunter agreed both in the diagnosis and in the propriety of refusing operation. The patient then left the institution, and I did not see her for five or six months, when she returned again urgently demanding operation. I kept her in my service for some time, and then, with regret, again dismissed her without having afforded her any permanent relief.

Two months after this she saw me at my office, and so fully described her sufferings, and

so earnestly pleaded for relief that I again admitted her to the hospital, promising to remove the ovaries by Battey's method, in the hope of, in this way, relieving her of at least the greater portion of her troubles. For this operation, she entered my service during the year 1881.

I cut down through the abdominal walls, and reached a tumor which looked exactly like a fibroid. I put my fingers upon it, and was surprised to find an obscure and yet distinct sense of fluctuation, which had not been recognized through the abdominal walls. Instead, therefore, of going on with the intended operation, I introduced a canula and trocar into the fluctuating tumor, and on withdrawing it there immediately escaped a pint or a pint and a half of menstrual fluid. It had all the characteristics of that fluid, and there could be no mistake with regard to its nature. I was very much puzzled by this, for the woman had been carefully examined, she had menstruated regularly, the uterus had been repeatedly measured, and was found to be two inches and a half in length. Taking hold of the tumor with two strong tenacula and drawing it up into the abdominal wound, I passed my hand down and discovered its relations, when at once it flashed across my mind that this was a uterus bicornial; that the canal in the left horn was free, and allowed the escape of the menstrual fluid from that side, while the canal in the right horn was not open throughout its entire length, and consequently obstructed the menstrual discharge from that side.

The original condition of the parts was probably that represented in Fig. 9 or Fig. 10, one cervix being pervious, and the other impervious, if the uterus were originally bicornate as represented in Fig. 9, or else no cervix existing if the organ were originally unicornate as represented in Fig. 10.

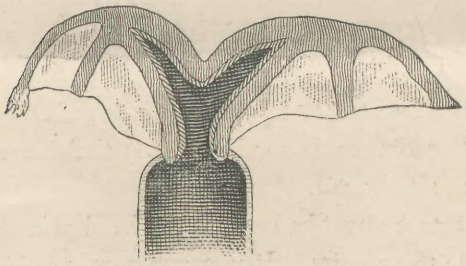

FIG. 9.—BICORN UTERUS.

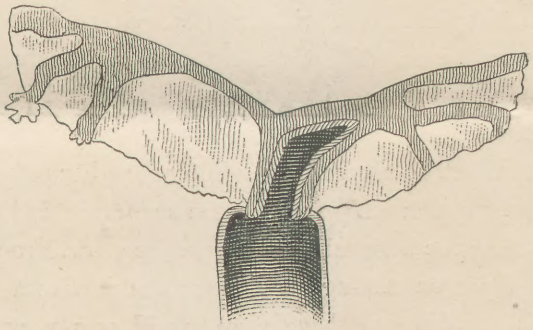

FIG. 10.—UNICORN UTERUS.

Under such circumstances, one uterus, or rather one horn, discharges menstrual blood; in the other, that fluid, secreted by the endometrium, accummulates and creates a tumor presenting many of the features of a fibroid.

When this thought suggested itself I was able to account for all the peculiarities of the case: First, the fact that the tumor had the appearances of a fibroid, and gave such agonizing pain at each menstrual period; second, the fact that the tumor remained at about the same size, not growing larger, as a fibroid would do, although it was not at all impossible for a tumor of this character to have become larger by gradual distension; and, lastly, the fact that the patient had comparative immunity from pain between the menstrual periods. I now found myself in an unfortunate dilemma, for had I proceeded to remove the ovaries, blood would have escaped from the wound into the abdominal cavity, and would very likely have set up fatal peritonitis or septicæmia. Hence, I adopted a course which struck me, as under the circumstances, the only one which would meet the emergency.

The following diagram, Fig. 11, will show the condition of affairs at this stage of the operation.

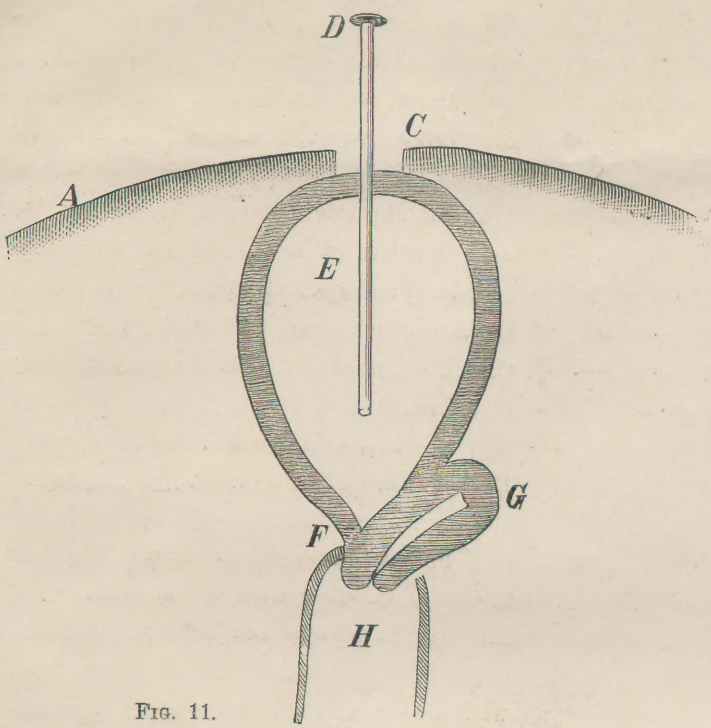

FIG. 11.

A. B. Abdominal Walls. C. Section in median line. D. Canula. E. One uterine body distended by retained menstrual blood. F Urine uteri, impervious on one side. G. Uterus with pervious cervical canal. H. Vagina.

I caught hold of the uterus on one side, and Dr. Ward on the other, each with a strong tenaculum, and dragged it firmly up into the abdominal wound, and passed two strong knitting-needles through the tumor and laid them on the abdominal walls above and below the point of puncture. I then passed two sutures deep down, and fastened the tumor in the abdominal wound, and left a tube in for drainage and irrigation. I remarked to the spectators present, that the woman would almost surely suffer from septicæmia, and this prediction was fully verified; but by having the cavity constantly irrigated with carbolized water, and controlling the temperature by Kibbee's method of affusion, she recovered. A day-to-day history would accomplish nothing in increasing the interest of the case, hence, I spare the reader a recapitulation of it. It suffices to say that the uterine cavity was thoroughly washed out with carbolized water every four or five hours; the temperature, which rose to 106°, kept in the neighborhood of 100° by affusion; and quinine and opium used freely; and the patient treated in all respects as she would have been after ovariotomy.

At the next period, menstrual blood escaped simultaneously from the vagina and the abdominal wound, the drainage tube not having been removed from the latter. Never have I known more complete relief ensue from any operation than from this one. The patient constantly expressed herself as entirely relieved, and is so well satisfied with her present condition that she is entirely unwilling to consider a procedure to which I shall soon allude for improving it.

For her, however, to continue in her present state of comfort, it is evidently essential that the abdominal opening shall be kept free until the menopause. To accomplish this, as soon as the menstrual period was over, I had constructed a solid glass rod represented in actual size by Fig. 12.

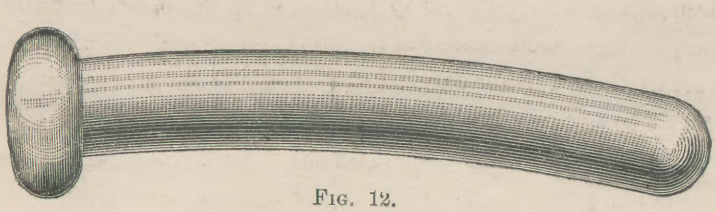

FIG. 12.

This, the patient wears constantly, except at menstrual periods, keeping it in position by a girdle which presses upon its head, and at the same time sustains the parts about the incision.

She has now left the hospital, but reports to me occasionally, and has been instructed how to allow the free escape of menstrual blood by the genu-pectoral position, and how to wash out the cavity with carbolized water, in case of any septic symptoms attending upon or following menstruation. This last maneuvre she has frequently practiced, and perfectly understands. Fig. 13, although a rough diagram, represents very accurately, I think, the present state of affairs.

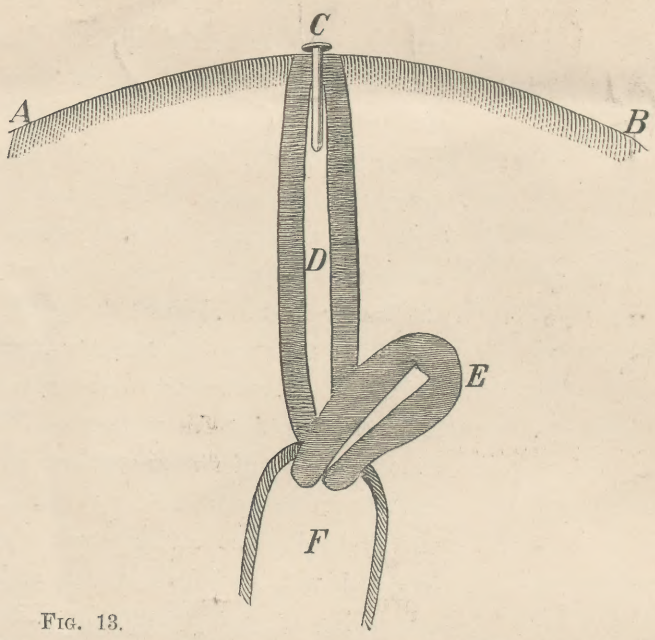

FIG. 13.

A. B. Abdominal walls. C. Glass plug. D. Uterine body fastened to the abdominal walls. E. Uterus with pervious cervical canal. F. Vagina.

When this operation was adopted, I felt that it had helped my patient and myself out of a very difficult dilemma, but at the present time I do not feel at all satisfied with the *status rerum.* Should the patient not become pregnant, it is highly probable that all will go well with her until the menopause, but should pregnancy occur in the left horn, the right will assuredly be torn away from its abdominal moorings, and a fatal issue would occur.

At the moment of operation, and since that time, the propriety of penetrating the impervious cervical canal of the right horn, keeping it permanently open, closing the upper opening, dropping this horn into the pelvic cavity, and then closing the abdominal wound, has been carefully considered.

As is so often the fact, under similar circumstances, the advisability of this course will very likely be immediately determined upon by many who have not had an opportunity of observing the case. To those who have watched it with keen anxiety, through its various phases, much more difficulty will attend the decision. The patient is past forty; should conception occur the propriety of checking utero-gestation would be quite evident; the patient, who has gone through with a great deal of suffering, strenuously objects to interference with a condition which is perfectly satisfactory to her and the dangers attendant upon the steps referred to would be very considerable.

So many years have elapsed since pregnancy occurred with her, that I think it highly improbable that it will now take place after the fortieth year. Should it do so, I should feel myself called upon under present circumstances to put a stop to its progress. This, however, I should feel justified in doing only once; having once resorted to it as a therapeutic resource, I should feel it my duty to urge upon her a resort to those further surgical steps which I have mentioned.

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